# Exhibit 17

U172772U11 13:51 FAX

ख्रि एक्हर एउउ

#### Jeff S. Pierce, D.O. Michigan Sport and Spine Center 1819 E. Big Beaver Rd., Suite 210 Troy, MI 48083

Physician:

Test Date:

Patient:

Redacted

Sex:

Male

Ref. M.D.:

DR, KARRUMI

D.O.B.

Redacted

# Motor Nerve Study

Peroneal Nerve Rec Site: EDB

STIM SITE Ankle B,Flbuler

Lat (ma) R 5.8 14.8

13.4

Dur (ms)

Amp (mV) R 1.7 2.7 2.2 5.5

Amplitude

Area (m\/ma) Dist (mm) R

C.V. (m/s)

Jeff S. Pierce, D.O.

12/17/10

46.7 42.1

#### Sensory Nerve Study

Sural Nerve

Rec Site: Ankle STIM SITE mid celf

Let (ma) 3.1 3,0 Pk Lat (ms) Amp (uV) R 7.1 4.1 4.0 9.8

Dist (mm) ø 0

C.V. (m/s)

370 375

#### F-Wave Study

Peronesi Nerve Rec Site: EDB

Stim Site: Ankle M wave Fwave

me m∀ 13,83 15.00 48.67 46.50 3.75 9.17 1.50 1.50 34.83 31.50

Latency

H Reflex Study

F-M

Nerve Rec Site: Soleus Stim Site: Pop.Fos.

Letency Amplitude ITNS mV R 4.83 5.00 3.50 3,50 34.00 33.67 2.50 2.50

M wave H wave

**EMG Study** 

Name L. Vastus Med. Ins Act

P.Waves Fescies

Fibs

Rep

WG.emp MC.amp MU dur Phasics

Rec Pet TEXT

		4 <u>€</u> 045/453
	AGA STATE	M INSURANCE
1500	FAX 888-84	
1500	PO BOX 236	61
EALTH INSURANCE CLAIM FOR		ON IL 61702
PROYED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/01 [7] PICA		PIGA
MEDICARE MEDICAID TRICARE	CHAMPVA GROUP FECA OTHER	1a. INSURED'S LD. NUMBER (For Program in Norm 1)
(Medicale #) (Medicald #) (Sponsor's SSM)	CHAMPVA GROUP FECA OTHER BLK LUNG X (ID)	22B177093
Redacted	Redacted **	Redacted
	6. PATIENT RELATIONSHIP TO INGURED	4
	Solf X Spouse Child Other	
	8. PATIENT STATUS	1
	Bingle Marriad Other	
	Employed Full-Time Park-Time	
OTHER INSURED'S NAME (Lest Name, First Name, Middle In		11, INSURED'S POLICY GROUP OR FECA NUMBER
Austral despositives to statum frame commits t ser Lansie, which or		
OTHER INSURED POLICY OR GROUP NUMBER	*, EMPLOYMENT? (Current or Pravious)	Redacted MK F
TO THE PART OF SITE A	TYES NO PLACE (SIMIN)	A STATE OF S
OTHER INSURED'S DATE OF BIRTH SEX	K YES NO MI	<b>'</b>
EMPLOYERS NAME OR SCHOOL NAME	C, OTHER ADDIDENT?	a risurance plan name on program name STATE FARM INSURANCE
	YES NO	E. IS THERE ANOTHER HEALTH BENEFIT PLANT
INSURANCE PLAN NAME OR PROXIMAM NAME		YES X NO # year, return to end complete item 9 a-d.
READ BACK OF FORM BEPORE C	CHIPLETING & SIGNAG THIS FORM.	73, INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I surrouse payment of medical benefits to the undensigned physician or supplier to surrouse described below.
2. PATIENTS OR AUTHORIZED PERSON'S BIGMATURE I AU to process this dialine. I also request payment of government is	DIRECTIONS & SECRETARY THIS FORM. Shorks the release of any medical or other information necessary permitties officer to myself or to the party who accepts assignment	services described below.
SIGNATURE ON FILE	01 06 11	SIGNATURE ON FILE
SIGNED	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM L DD L YY	
M. 1290 LO YY INJUST (First symptom) OR INJUSTY (Academ) OR PREGNANCY (LMP)		FROM TO
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
THE OPEN TAX STORY OF THE SECOND SECTION SECTI	The state of the s	
	170 NPI 1233113771	FROM 70  20. OUTSIDE LAB? 8 CHARGES
B. REBERVED FOR LOCAL USE	175 NP 1233103171	PROM "" TO 20. OUTSIDE LAB? & CHARGES O 0 0 0
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BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

#### REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health Insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, consurance and noncovered services. Consurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted, CHAMPUS is not a health insurance program but makes payment for health benefits provided through cartain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 13.

#### BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (#EDICARE, CHAMPUS, FECA AND BLACK LUNG)
I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident on my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS

For services to be considered as 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Scrytces or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

# NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411,24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, hoaith plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to discuss information about the benefits you have used to a hospital or doctor. Additional discussures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled. 'Carrier Medicare Claims Record,' published in the Federal Rogistor, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAUMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," <u>Federal Register</u> Vol. 55 No. 40, Wed Fcb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOH CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitioment, cialms adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party hability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1986", permits the government to verify information by way of computer matches, MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claims will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State taws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OWB control number. The valid OWB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn. PBA Reports Clearence Officer. 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT WAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

02/24/2011 08:47 FXX

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# Michigan Spine & Rehab 23861 W. McNichols Detroit, MI 48219 (313) 769-3868

Redacted Patient: Female Sex: S.S. No.

Redacted THAKUR

Ref. M.D.: Redacted D.O.B.

Physician: Test Date:

Jeff S. Pierce, D.O.

02/04/11

Mo	her	Name	Study
44.V	LUI.	TARKAR	DULLY

Left Medien-Liner N Res Ske: APB-ADM		Phys. (co.e.)	44-18	A days 8	Police 1 h	
STIM SITE	rest Assol	Dur (ms)	Amp (mV)	Area (mVms)	Dist (mm)	G.V. (m/s)
M Write	5.2		7.3		a	
Elbow	9,8		5.7		280	49.3
Median-Uinar Nerve		•				
Rec Site: APB-ADM	Lat (ms)	Dur (me)	Amp (mV)	Area (mVms)	Dist (mm)	C.V. (m/s)
STIM SITE	L Ř	L R	L R	L R	L R	L B
M Wrist	4.2		4.7	,	0 0	- ''
Elbaw	B.4		2.4		215	50.6
U Wrist	4.0		7.9		0	
B.Elbow	7,2,		7.7		295	74.2
A.Elbow	10.3		7.2		145	47.0
Right Median-Liner &	Narve					
Rec Ste: APB-ADM	Let (ms)	Dur (me)	Amp (mV)	Area (mVms)	Dist (mm)	C.V. (m/s)
etim site	•	• •				
U What	4.2		3.6		0	
8.Elbow	7.3		10.B		230	726
A.Elbow	9.9		4.7		125	48.4

#### Sensory Nerve Study

Med/Utr/Red Norve Stim Site: Wrist	Lat (ı	ns)	Орг	(ms)	Аптр	(uV)	Dist	(mm)	C,Y.	(m/s)
rec site	L	R	L.	R	L '	`R`	L	`R`	L	`R
M Thumb	4.5	3.2	•		7.3	105.3	Ö	0		
R Thumb	1,6	3.0			21.7	3.3	ō	Ö		
index	4.8	3.4			18.7	21.7	٥	Ö		
D2 MdPalm	5.0	1.8			3.7	19.3	Ö	Ó		
Eth dig	4.7	4.1			1.7	5.0	0	Ď		

#### F-Wave Study

Median-Uiner Nerve		
Rec Site:	Latency	Amplitude
Stim Sile:	កាន់	mΥ
	L R	LR
M wave	5.0D 4.00	10.08 8.25
FWIVE	33.83 34.25	15.00 15.00
F-M	26,63 30,26	

0272472011		<u>a</u> vv8/058
		,
		, YMA(10 2 MA)
500)	STATE FARM FAX 888-04	INSUKANCE
	PO BOX 236	
EALTH INSURANCE CLAIM FORM PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE BRIDE	BLOOMINGTO	N IL 61702
TIPICA		PICA
	AMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG (7)	1a. INGURED'S I.D. NUMBER (For Program in liam 1)
(Madicare #) (Madicaid #) CHAMPUS SSN) (Me	miser (DE) (SBN or ID) (SBN) X	22B178522 4. INSUREDS NAME (Les Norme, First Name, Middle Initial)
PATIENT'S NAME (Last Name, Fliet Name, Middle Initial)	3. PATIENTS BIRTH DATE BEX	Redacted
ledacted	Redacted M FX	1
	Self X Spouse Child Other	
	8. PATIENT STATUS	
•	Single Marriad Other X	<u> </u>
	Employed Student Student	
	10. IS PATIENT'S CONDITION RELATED TO:	II, INSUMED STOCK CITCOL ON PERSONNELL
		a INCLUDED STATE OF HIGH
	EMPLOYMENT? (Cumant or Previous)	Redacted M FX
	D, AUTO ACCIDENT? PLACE (BLUE)	b, EMPLOYER'S NAME ON SCHOOL NAME
	TES TONO	
EMPLOYER'S NAME OR SCHOOL NAME	a. OTHER ACCIDENT?	D. INSURANCE PLAN NAME OF PROGRAM NAME
	YES X NO	STATE FARM INSURANCE  4. IS THERE ANOTHER HEALTH BENERT PLAN?
	104. RESERVED FOR LOCAL USE	YES NO # yee, return to and complete bein 9 s.d.
INSURANCE PLAN NAME OF PROGRAM NAME	•	
INSURANCE PLAN NAME OF PROGRAM NAME  BLUE CROSS/BLUE SHIELD  OF AN RACK OF FORM REFORE COMP	LETING & SIGNING THE FORM	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I sufficient
INSURANCE PLAN NAME OF PROGRAM NAME  BLUE CROSS/BLUE SHIELD  READ BACK OF FORM REPORTE COMP  PATIENT'S OR AUTHORIZED PERSONS SIGNATURE I author  to process the playm is give request persons of givenment base.	LETING & SIGNANG THE PORIS.  To the release of any medical or other information necessary the since to myself of to the party who accepts easignment	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I sulhointe payment of medical benefits to the undereigned physician or aupplier for envices described below.
BLUE CROSS/BLUE SHIELD  PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I author to process this claim. I also request payment of government bane pelow.		13. NSURED 8 OR AUTHORIZED PERBOYS SIGNATURE: suthorize payment of medical penalis to the underlighed physician or supplies for services described below.
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WOMEN FOODS

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any falsa, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

#### REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process MEDICARE AND CHAMPUS PAYMENTS: A patent's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-lault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare carim is made. See 42 CFR 411.24(a). If them 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, consurance and noncovered services. Consurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services, Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

#### **BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were turnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare of CHAMPUS regulations.

For services to be considered as 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or fatsities essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

# NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FEGA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended. 42 CFR 411,24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to discrose information about the benefits you have used to a hospital or doctor. Additional discrosures are made through routine uses for information contained in systems of records.

FOR MEDICARE:CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974. "Republication of Notice of Systems of Records." <u>Federal Register</u> Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6. ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Deterise in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, end individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party tability, coordination of benefits and civil and criminal hitigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denal of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the mucical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION) I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claurifyeld be from Federal and State funds, and that any false clauris, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OVB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions. Search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Athr. PRA Reports Clearence Officer 7500 Security Boulevard, Baltimoro. Maryland 21244-1850. This address is for comments and/or suggestions only DONOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

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Michigen Spine & Rehab 28881 W. McNichols Detroit, MI 48219 (313) 759-8888

Sex: F	edact	<u>ed</u>		Physicia Test Da		FS. Pierce, D.O. /16/11	,
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Motor Nerve B	tady						
Jak Mariko-Ukur Ni Roc Sile: APS-ADN BTIN SITE	kyż Lat (ms)	Dar (92)	Amp (miv)	Area (mVms)		C.V. (min)	
H Wrist Blow	4.7 3.9		435 8:1		t 180	240.0	
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1500 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/06	FAX 888-8 PO BOX 23		PICA TTT.
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP  (Medicare #) (Medicare #) (Sponeor's SSN) (Member iDe) (SSN or #)	PLAN FECA OTHER DIK LUNG X(ID)	18. INSURED'S LD, NUMBER 22B149302	(For Program in 11em 1)
Redacted Redaction Redaction	ATIONSHIP TO INSURED  Child Dither	Redacted	
S. OTHER INSUREU'S NAME (LEST NAME, FIRST NAME, MIXING TRIBIT)  10. IS PATIENT:	Full-Time Pan-Time Student Student Student To:		
a. OTHER INBUREO'S POLICY OR GROUP NUMBER II. EMPLOYMEN	T7 (Current or PreMove) YES X NO		
b. OTHER INSURED'S DATE OF BIRTH SEX b. AUTO ACCIDE MM OD YY M F	YES X NO (State)	b, EMPLOYER'S NAME OF SO	HOOL NAME
d. INBURANCE PLAN NAME OR PROGRAM NAME  a. OTHER ACCID  d. INBURANCE PLAN NAME OR PROGRAM NAME  10d. REGERVED	YES NO FOR LOCAL USE	o. INSUFANCE PLAN NAME OF STATE FARM 1	NSURANCE THEENERT PLAN?
PEAD BACK OF FORM BEFORE COMPLETING & SIGNANG THIS  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any made to proceed the claim. I also request payment of government benefits either to myself or to the	FORM. al or other information necessary a party who accepts assignment	YES Z NO  13. INSURED'S OR AUTHORIZ payment of madical benefits services described below.	# yes, return to and complete item 9 a-d.  EO PERSON'S SIGNATURE I sunhorize to the undersigned physician or supplier for
SIGNATURE ON FILE SIGNATURE ON FILE DATE	03 16 11	SIGNAT	URE ON FILE
MM DD YY INJURY (Academ) DR GIVE FIRST DATE	MM DD YY	FROM DD '	TO WORK IN CURRENT OCCUPATION YY TO MM   DO   YY TO
77. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178.   179.	103771	18. HOSPITALIZATION DATES FROM   DO   20. OUTSIDE LAB?	RELATED TO CURRENT SERVICES YY TO YY S CHARGES
21. DIAGNOSIS DA NATURE OF ILLNESS OR INJURY. (RAMA 1,2,3 of 4 to Ham 246 to 1.1	uy Linė)	YES NO 22. MEDICALD RESUBMISSION CODE   23. PRIOR AUTHORIZATION N	OHIGINAL HEF. NO.
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25, FEDERAL TAX I.D. NUMBER SSN EIN 28, PATIENT'S ACCOUNT NO. 205918486 X 21700C6527	27. ACCEPT ASSKSNIMENT? (For gord, claims, sae back)	3010 00 8	### 1   1   1   1   1   1   1   1   1
31. SIGNATURE OF PHYSICIAN OR SUPFLIER INCLUDING DEGREES OR ORSEDENTIALS (I certify that the graterneoils or the traverse spoply to this DM and are made a part the lead.)  JEFF SCOTT PIERCE DO  DETROIT MI 4823	& REHAB DT	33. BILLING PROVIDER INFO MICHIGAN SPI 5761 W MAPLE WEST BLOOMFI	ne and rehab
SIGNED 03 31 11 AT518027606 B. NUCC Instruction Manual available at: www.nucc.org			0938-0999 FORM CMS-1500 (08/05)

# Michigan Spine and Rehab 23861 W McNichols Detroit, MI 48219

### Electrodiagnostic Report EMG/NCV

Patient Name:

Redacted

Recording Date:

6/28/2012

Birth Date:

Redacted

Ref Doctor:

Dr. Fitch

History:

Pt is right-handed, and she c/o b/l posterior cervical pain and b/l upper extremity pain, paresthesias and weakness extending into all of her fingers of both of her hands. She also c/o b/l low back pain and b/l lower externity pain, paresthesias and weakness extending posteriorly to her heels. This all began - 3 years ago.

# <u>IMPRESSIONS BILATERAL UPPER EXTREMITIES</u>

1. Abnormal study.

2. Electrodiagnostic evidence suggestive of bilateral C6-C7 radiculitis.

 Electrodiagnostic evidence of right median sensorimotor neuropathy consistent with moderate right carpal tunnel syndrome.

4. Electrodiagnostic evidence of left median sensory neuropathy consistent with mild left carpai tunnel syndrome.

5. Electrodiagnostic evidence of ulnar sensory neuropathy bilaterally.

- 6. No electrodiagnostic evidence of ulnar motor neuropathy bilaterally.
- 7. No electrodiagnostic evidence of radial neuropathy bilaterally.
- 8. No electrodiagnostic evidence of cervical myopathy or plexopathy bilaterally.

## IMPRESSIONS BILATERAL LOWER EXTREMITIES

- 1. Abnormal study.
- 2. Electrodiagnostic evidence suggestive of bilateral L5-S1 radiculitis.
- 3. No electrodiagnostic evidence of peroneal motor neuropathy bilaterally.
- 4. No electrodiagnostic evidence of tibial motor neuropathy bilaterally.
- 5. Electrodiagnostic evidence of sural sensory neuropathy on the right.
- 6. No electrodiagnostic evidence of sural sensory neuropathy on the left,
- 7. No electrodiagnostic evidence of lumbar myopathy or plexopathy bilaterally.

Thank you for the opportunity to participate in the care of your patient.

Sincerely,

Katherine H. Karo, DO Physical Medicine & Rehabilitation Redacted

GB12L53DBW

6/28/2012 11:37:28 AM

MNCV	She/Segment	Latency	Amp	Dur	E61A	Distance	Velocity
Median R	4274 A 4565 TH	m <sub>b</sub>	mV.	ms	mVms	mm .	m/s
MANUAL EZ	Wrist-APB 7cm	7,9	1.B	9.3	9.0		(10.000000
	Elbow-Wrist	11.9	1.2	3.4	1.7	210	52.9
Ulnar R	Wrist-ADM 7cm	2.7	5.0	, 7.3	19.5		72.0
	Below Elbow-Wrist	6.9	7.8	7.0	28.0	220	52,6
Median L	Wrist-APB 7cm	4.2	5.2	8,0	25,1		*****
	Elbow-Wrist	8.1	6.6	8.0	25,4	190	48,2
Umar L	Wrist-ADM 7cm	31	6.8	7.2	23.8	· · · ·	7-7-7-7
	Below Elbow-Wrist	7.4	5.6	8.9	21.1	220	51.5
Peroneal R	Foot-EDB 9cm	3.3	5.1	8.4	16.0		3,,0
	Below Fib Head-Foot	10.1	4.0	7.3	10.5	300	44.3
Tible R	Ankle-AH Bom	5.3	6.1	5.5	18.2	447	77,0
	Pop Fossa-Anide	13.5	7.0	6.3	5.7	400	48.9
Peroneel L	Foot-EDB 9cm	3.4	5.4	6.2	16.7		
	Below Fib Head-Foot	10.3	4.4	6.4	11,0	320	48,4
71blai L	Ankle-AH 8cm	4,5	8.0	5.4	13.0		
	Pop Fossa-Ankle	12.5	1.3	7.4	1,0	400	49.6

SNCV	Site/Segment	Latency	Amp	Our	Ārea	Distance	Velocity
		. ITS	υV	≠ns	uVms	mon	m/s
Median Dig II R	Wrist-Digit II 14cm	2,1	0.00				NO
Ulpar Dig V R	Wrist-Digit V 14cm	3.5	5,53	······		140	40.6
Radial Snuff box R	Foresm-Snuff Box 10cm	2.2	9.11		<del>                                     </del>	110	50.0
Median Dig II L	Wrist-Digit il 14cm	4.5	10.4	-		160	35.9
Ulnar Dig Y L	Whist-Digit V 14cm	3.7	19.0	·	<del> </del> -	150	40.6
Radial Snuff box L	Forearm-Smiff Box 10cm	2.4	14.9	<del></del>		110	45.8
Sural R	Gestroc-Lat Mell 14cm	6.4	15.0			140	22.0
Soral L	Gastroc-Lat Mail 14cm	3,1	12,6	*****		140	45.9

f min latency ms
29.7
30.7
26.8
28.2
48.3
48.2
45,5
35.0

H Reflex	H Latency
777107000	ins
Tiblal R	37.4
Tiblal L	37.2